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HOUSE BILL 3076
By Arriola

AN ACT to amend Tennessee Code Annotated, Title 49; Title 56; Title 68 and Title 71, relative to the Children First Insurance Plan.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is, and may be cited as the “Children First Insurance Plan Act”.

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part 25:

Section 71-5-2401. There is created the Tennessee Children First Insurance Plan.

Section 71-5-2402. As used in this act, unless the context otherwise requires:

(1) "Board" means the board of the Children First Insurance Plan established pursuant to Section 71-5-2403; and

(2) "Plan" means the Children First Insurance Plan.

Section 71-5-2403.

(a) The Children First Insurance Plan shall be governed by a board of nine (9) directors to be appointed by the governor. Four (4) members of the board shall be

citizens who are advocates for children and who are not affiliated with an insurance company or a health maintenance organization for three (3) year terms. Four (4) members of the board shall be representatives of health maintenance organizations and insurance companies licensed to issue health insurance in this state for three (3) year terms. The comptroller of the treasury shall be a voting ex officio member of the board.

(b) Each public member of the board shall serve for a term of three (3) years. Public members shall be eligible for reappointment. They shall serve until their successors are appointed and qualified, and the expiration of the term of that incumbent. A vacancy occurring other than by expiration of term shall be filled in the same manner as the original appointment but for the unexpired term only.

(c) The members of the board shall serve without compensation, but they shall be entitled to reimbursement for all necessary expenses incurred in the performance of their duties, in accordance with the comprehensive state travel regulations.

(d) The board shall appoint an executive director, who shall serve at its pleasure and shall be a person qualified by training and experience to perform the duties of the office.

Section 71-5-2404.

(a) Any child eligible for and enrolled in medical assistance under title 71, chapter 5, part 1, shall be enrolled in the Children First Insurance Plan. The bureau of TennCare shall contract with the plan and the corporation to provide medical assistance to enrolled children.

(b) Any child enrolled in the TennCare Select program shall be transferred to the Children First Insurance Plan and appropriate capitation payments and premiums for any such child shall be transferred to or paid to the plan. Such children shall be screened for risk factors within thirty (30) days of enrollment in the plan by an appropriately licensed health care professional.

(c) The Children First Insurance Plan shall offer to enroll any child currently covered by health insurance coverage or a group health plan for a premium to be set annually by the board.

(d) Enrolled children shall receive the medical assistance provided for in Section 71-5-106 as the benefit package of the plan. To the maximum extent permitted by federal law, early periodic screening, diagnosis and testing services shall be provided at plan expense to enrolled children who are children with disabilities receiving special education services under title 49, chapter 10.

Section 71-5-2405. The corporation created by the Children First Insurance Plan shall operate as a health maintenance organization or insurance company subject to the requirements of Title 56 in order to provide medical assistance coverage to children. The corporation shall be authorized to enter into an agreement with the Children First Insurance Plan Reinsurance Pool pursuant to SECTION 3 of this act in order to assure coverage of catastrophic events. The corporation is authorized but not required to use methods of managed care as permitted under law. Such methods may include, but are not limited to the use provider networks.

Section 71-5-2406. (a) The board is hereby authorized to create a not-for-profit corporation to raise funds, develop, manage and implement the plans and programs of the Children First Insurance Plan.

(b) The board is authorized to select a name for the corporation. The corporation shall have its own board of directors which shall consist of the members of the board of the plan, a representative appointed by the governor, and a representative of the attorney general and reporter. The board may select its own chair with the approval of the chair of the commission.

(c) After proper incorporation, the not-for-profit corporation is authorized and directed to apply for tax-exempt status under § 501(c)(3) of the Internal Revenue Code [26 U.S.C. § 501(c)(3)].

(d) In addition to funds received from the assessments from the reinsurance pool and premiums, the corporation may receive funds from the state at such times and in such amounts as appropriated by the general assembly to be used for its tax-exempt purposes.

(e) Upon its incorporation, the not-for-profit corporation shall be responsible for implementing such programs as the board plans. The not-for-profit corporation may hire such support staff and name such advisory groups or steering committees as necessary to assist in the promotion, coordination, and implementation of and fundraising for the comprehensive program developed by the board of the plan.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 32, is amended by adding the following as a new part 3:

Section 56-32-301.

(a) In addition to any fee or tax imposed pursuant to Section 56-32-224, there is also imposed on each health maintenance organization doing business in this state an assessment that shall be determined annually in accordance with the provisions of this section. After such assessment is collected by the commissioner of commerce and insurance, the assessment shall be paid to the general fund and allocated to the Children First Insurance Plan for providing medical assistance and related services.

(b) Each year after the actuarial study required by Section 71-5-188, the commissioner of commerce and insurance shall determine the level of funding required for a reinsurance pool to cover excess costs incurred by the Children First Insurance Plan. Such costs shall include costs incurred by such plan due to catastrophic illnesses and other revenue shortfalls. The commissioner shall divide the estimate of costs

between insurance companies subject to tax under Chapter 4 of this title and health maintenance organizations subject to tax under this chapter. The commissioner shall develop an assessment on each health maintenance organization [HMO] doing business in this state to collect the revenue needed for the proportional share of such costs to be paid by health maintenance organizations. The assessment shall be developed in accordance with the provisions of subsection (c) of this section.

(c)

(1) Each HMO's proportion of the state cost shall be equal to that HMO's proportion of its premium and subscriber contract charges for health insurance written in the state during the preceding calendar year as compared to the total of all premiums and subscriber contract charges written in the state. Each HMO's proportion of the cost shall be determined by the commissioner based upon annual statements filed with the department of commerce and insurance, or such other reports or information deemed necessary by the commissioner.

(2) The commissioner of commerce and insurance, with the approval of the commissioner of finance and administration, may abate or defer, in whole or in part, the assessment of an HMO if, in the opinion of the commissioners of commerce and insurance and finance and administration, payment of the assessment would endanger the ability of the HMO to fulfill its contractual obligations. In the event an assessment against an HMO is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other HMOs in a manner consistent with the basis for assessments set forth in this section. The HMO receiving such abatement or deferment shall remain liable to the department for deficiency for four (4) years.

(3) It is unlawful for any HMO to fail or refuse to pay an assessment or to respond to an inquiry from the commissioner regarding information necessary to

make assessments within forty-five (45) days of the assessment notice or request for information.

(4) Whenever the commissioner has reason to believe that an HMO has failed or refused to pay an assessment, or has failed or refused to respond to a request for information necessary to make assessments in a timely fashion or has failed or refused to register in accordance with the provisions of this section, the commissioner may issue and serve upon such an HMO a notice of hearing to determine whether the HMO has failed or refused to pay an assessment or respond to an inquiry or register in a timely fashion. Such hearing shall be conducted in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5.

(5) If, after notice and hearing, the commissioner determines that the HMO has failed or refused to pay an assessment, or has failed or refused to provide information necessary to make assessments in accordance with this section, or has failed or refused to register in accordance with the provisions of this section, the commissioner may assess a civil penalty of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each and every act or violation. Each day in which the HMO has failed or refused to pay an assessment or to provide information necessary to make assessments or register in accordance with this section constitutes a separate act or violation. The commissioner may, if the commissioner determines that the HMO knew or reasonably should have known that such member was in violation of this section, suspend or revoke the HMO's certificate of authority to transact business in this state.

(d) The commissioner shall establish the amount of assessment pursuant to this section, annually at the end of each calendar year, and the assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice.

Section 56-3-302.

(a) In addition to any fee or tax imposed pursuant to Section 56-32-224, there is also imposed on each health maintenance organization doing business in this state an assessment that shall be determined annually in accordance with the provisions of this section. After such assessment is collected by the commissioner of commerce and insurance, the assessment shall be paid to the general fund and allocated to the Children First Insurance Plan for providing medical assistance and related services.

(b) Each year after the actuarial study required by Section 71-5-188, the commissioner of commerce and insurance shall determine the level of funding required for a reinsurance pool to cover excess costs incurred by the Children First Insurance Plan. Such costs shall include costs incurred by such plan due to catastrophic illnesses and other revenue shortfalls. The commissioner shall divide the estimate of costs between insurance companies subject to tax under Chapter 4 of this title and health maintenance organizations subject to tax under this chapter. The commissioner shall develop an assessment on each insurance company doing business for health insurance coverage, as such coverage is defined in Section 56-7-2802, in this state to collect the revenue needed for the proportional share of such costs to be paid by such insurance companies. The assessment shall be developed in accordance with the provisions of subsection (c) of this section.

(c)

(1) Each insurance company's proportion of the state cost shall be equal to that insurance company's proportion of its premium and subscriber contract charges for health insurance written in the state during the preceding calendar

year as compared to the total of all premiums and subscriber contract charges written in the state. Each insurance company's proportion of the cost shall be determined by the commissioner based upon annual statements filed with the department of commerce and insurance, or such other reports or information deemed necessary by the commissioner.

(2) The commissioner of commerce and insurance, with the approval of the commissioner of finance and administration, may abate or defer, in whole or in part, the assessment of an insurance company if, in the opinion of the commissioners of commerce and insurance and finance and administration, payment of the assessment would endanger the ability of the insurance company to fulfill its contractual obligations. In the event an assessment against an insurance company is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other insurance companies in a manner consistent with the basis for assessments set forth in this section. An insurance company receiving such abatement or deferment shall remain liable to the department for deficiency for four (4) years.

(3) It is unlawful for any insurance company to fail or refuse to pay an assessment or to respond to an inquiry from the commissioner regarding information necessary to make assessments within forty-five (45) days of the assessment notice or request for information.

(4) Whenever the commissioner has reason to believe that an insurance company has failed or refused to pay an assessment, or has failed or refused to respond to a request for information necessary to make assessments in a timely fashion or has failed or refused to register in accordance with the provisions of this section, the commissioner may issue and serve upon such an insurance company a notice of hearing to determine whether the insurance company has

failed or refused to pay an assessment or respond to an inquiry or register in a timely fashion. Such hearing shall be conducted in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5.

(5) If, after notice and hearing, the commissioner determines that the insurance company has failed or refused to pay an assessment, or has failed or refused to provide information necessary to make assessments in accordance with this section, or has failed or refused to register in accordance with the provisions of this section, the commissioner may assess a civil penalty of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each and every act or violation. Each day in which the insurance company has failed or refused to pay an assessment or to provide information necessary to make assessments or register in accordance with this section constitutes a separate act or violation. The commissioner may, if the commissioner determines that the insurance company knew or reasonably should have known that such member was in violation of this section, suspend or revoke the insurance company's certificate of authority to transact business in this state.

(d) The commissioner shall establish the amount of assessment pursuant to this section, annually at the end of each calendar year, and the assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice.

SECTION 4. Tennessee Code Annotated, Title 49, Chapter 10, is amended by adding the following as a new section:

Section 49-10-116. To the maximum extent permitted by federal law, early periodic screening, diagnosis and testing services shall be provided at plan expense to enrolled children who are children with disabilities receiving special education services under this chapter.

SECTION 5. Sections 1, 2 and 4 of this act shall not take effect until ninety (90) days after the director of the bureau of TennCare has determined either that:

(1) The state does not require a federal waiver in order to lawfully implement the provisions of this act that waives any or all of the provisions of title XIX, an amendment to any such existing waiver, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan; or

(2) The state has secured all necessary approvals from the federal secretary of health and human services or other appropriate federal official for any such amendment or waiver.

SECTION 6. The commissioner of finance and administration is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 7. The provisions of this act shall not be construed to be an appropriation of funds and no funds shall be obligated or expended pursuant to this act unless such funds are specifically appropriated by the general appropriations act.

SECTION 8. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 9. For the purpose of securing necessary approvals, making appointments, promulgating rules and entering into interagency agreements, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes this act shall take effect July 1, 2003, the public welfare requiring it.